BES/Form 114-I

# Utah Department of Health
## AUTHORIZATION TO RELEASE INSURANCE INFORMATION

7/03

Date:

To: _____

_____

_____

From: _____
BES Worker Name

_____
Phone # Fax #

_____
Address

Attn: Policy Owner Services
Re: _____ _____
Policy Number Insured

You are hereby authorized to release to the Department of Health, in verbal or written form, any information you have regarding the above insured. Further, you are hereby released from any and all liability for having released the information to the Department of Health.

_____ _____
Insured Signature Date

**This section to be completed by the Insurance Company**

- □ Face Value . . . . . $_____
- □ Cash Value $_____ Outstanding loan/assignments $_____
  Penalty for early withdrawl? □ Yes □ No
- □ Cash value of dividends . . . . . $_____
  Dividends/interest paid: □ Monthly □ Quarterly □ Annual □ Other
  □ Paid to insured □ Accrued/Invested □ Pay Premium
- □ Current Death Benefit . . . . . $_____
- □ Owner of Policy _____
- □ Name of Beneficiary _____
- □ Does the insured have other policies with your company? □ Yes □ No
  If yes, please provide the above information on all policies held by your company.

Comments:

_____ _____
Insurance Company Authorized Signature Date